Pennsylvania

Medical Assistance Submission

to the House Committee

on

Oversight and Government Reform

COMMONWEALTH OF PENNSYLVANIA
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Mr. Henry A. Waxman
House of Representatives
Chairman
Committee on Oversight and Government Reform
2157 Rayburn House Office Building
Washington, DC 20515-6143

Dear Chairman Waxman:

Thank you for the opportunity to share Pennsylvania's views and analyses on seven CMS regulatory actions during the past year: cost limits for public providers (CMS 2258-FC); payment for graduate medical education (CMS 2279-P); payment for hospital outpatient services (CMS 2261-P); provider taxes (CMS 2275-P); coverage of rehabilitative services (CMS 2261-P); payments for costs of school administrative and transportation services (CMS 2287-P); and targeted case management (CMS-2237-IFC).

Attached are several documents Pennsylvania has put together that provide our assessment of the impact these regulations would have on our Medical Assistance program. These documents are our best analyses to date, and we will continue to refine our views to share with the Committee in the event that you would like information in the future.

Please do not hesitate to contact me at (717) 787-1870 if you have any questions on these materials or require additional information.

Sincerely,

Michael Nardone

Enclosures

Pennsylvania Medical Assistance Submission to the House Committee on Oversight and Government Reform

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BEFORE THE
DEPARTMENT OF HEALTH AND HUMAN SERVICES

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JOINT COMMENTS OF THE STATES OF
ALASKA, CONNECTICUT, ILLINOIS, LOUISIANA, MAINE, MARYLAND, MICHIGAN, MISSOURI, NEW HAMPSHIRE, NEW JERSEY, NORTH CAROLINA, OKLAHOMA, PENNSYLVANIA, TENNESSEE, UTAH, WASHINGTON AND WISCONSIN

These comments on the above-captioned proposed rules are submitted on behalf of the agencies and officials responsible for administering the Medicaid program in the States of Alaska, Connecticut, Illinois, Louisiana, Maine, Maryland, Michigan, Missouri, New Hampshire, New Jersey, North Carolina, Oklahoma, Pennsylvania, Tennessee, Utah, Washington and Wisconsin ("Commenting States").

Before commenting on the specific "issue identifiers" covered by the proposed rules, the Commenting States cannot emphasize strongly enough that in their totality the proposals are not necessary to ensure the financial integrity of the program, are in derogation of the way that Medicaid has been operated since its inception, will seriously impair the ability of States to maintain their Medicaid programs, and will cause substantial financial injury to the hospitals and other health care businesses and professionals that provide essential health care

services to children, their families, the elderly, the disabled and other needy populations. CMS says that its proposals are consistent with and required by current law, but they go far beyond any reasonable construction of the agency's authority, disrupt long-standing practices, and impose new and onerous administrative and fiscal burdens on State and local governments, as well as all manner of public health care providers, including public schools.

Far from "ensur[ing] the integrity" of the "Federal-State Financial Partnership," the proposed rules seriously jeopardize it, by re-defining the types of public entities and sources of public funds that States have long relied on to serve Medicaid beneficiaries and help support the Medicaid program. There are numerous providers throughout the country that have traditionally earned federal matching funds either by certifying their expenditures in serving Medicaid patients or by transferring their funds to the State for use as the non-Federal share in Medicaid payments. Those providers are established under long-standing state laws, operate with substantial public oversight, and are dedicated to fulfilling an important public mission. Their willingness to contribute their own funds to pay for the non-federal share of serving Medicaid beneficiaries, thereby reducing the burden on state taxpayers, has been welcomed and should be applauded. Yet under the new rule many, if not most, of these providers would not qualify as "units of government" and their contributions would no longer be acceptable as a source of the non-Federal share. The denial of federal financial participation will eliminate a critical piece of funding for these providers and impose substantial new financing burdens on State Medicaid agencies tasked with preserving access to care.

Even if public providers meet the stringent "unit of government" test, the new rules would allow federal Medicaid payments only where the non-federal share of expenditures can be traced directly to an appropriation of tax dollars. Yet traditionally, the non-federal share

of expenditures by public entities has come not only from these sources but also from other unquestionably legitimate sources, such as foundation grants, earnings from other hospital operations (including ancillary lines of business like gift shops or parking lots) and charitable contributions. States have also used funds from such sources as tobacco payments, university tuitions, and other fees to pay for Medicaid services. The proposed rules would not only bar the use of these sources to pay for federally-matched services, but would even limit some categories of tax-based appropriations.

Limiting payments to cost would cripple states' ability to offer incentives to governmental providers to operate more efficiently. For governmental entities like schools, small clinics and other entities that provide critical front-line primary care services, and which have traditionally been paid on a fee basis, the cost limitation would impose on them massive accounting and reporting requirements way out of proportion to the scope of their operations. The cost limit is contrary to the direction of the Medicare program, which has replaced cost reimbursement systems for virtually all of its provider groups.

Finally, the proposal that governmental providers retain every penny of reimbursement, apart from being impossible to implement, fails to appreciate that these providers frequently are funded in full by state or county appropriations, so that the retention requirement would prevent return of the federal reimbursement to the account that put up the funds in the first place.

As set forth more fully below under the specific "issue identifiers," the proposals are in all key respects inconsistent with current law and are terrible public policy. The sources of funds that would no longer be the basis for federal support are a legitimate category of public money. Each of the entities that now certifies expenditures based on these sources is serving a

public mission, and by committing their resources (including those earned through their other business operations) to serving the Medicaid population they are advancing the purpose of the Medicaid program in exactly the way that the program contemplates. Preventing use of payment methods that offer the prospect of a reward for efficient operations insures that health care costs will continue to increase at unacceptable rates. And burdening providers with chimerical rules such as being required to retain all payments made for Medicaid services insures that program administration would be even more complicated and contentious than it is today.

I. Sources of State Share and Documentation of Certified Public Expenditures (Proposed § 433.51(b))

CMS proposes to revise 42 C.F.R. § 433.51(b) in order to change the funds that may be considered as the non-Federal share in Medicaid expenditures from "public funds" to "funds from units of government," which under the proposed amendment to 42 C.F.R. § 433.50(a)(1)(i) would be defined as funds from a "city, county, special purpose district, or other governmental unit in the State with generally applicable taxing authority." A health care provider will be considered to be a "unit of government" only if the provider itself has taxing authority or is a part of a unit of government with taxing authority that is legally obligated to fund the health care provider's expenses, liabilities and deficits. Proposed 433.50(a)(1)(ii). The preamble to the rule further states that State and/or local tax revenue paid to a provider cannot be considered the non-Federal share if the funds are committed or earmarked for non-Medicaid activities. 72 Fed. Reg. 2239. CMS asserts that its rule is required by The Medicaid Voluntary Contribution and Provider Specific Tax Amendments of 1992, Pub. L. 102-234 ("Provider Tax Amendments").

Comment: The proposed rule embodies a radical curtailing of the types of public funds that have traditionally been used as the non-Federal share of Medicaid expenditures.

CMS's own past practices confirm that these changes do not flow from the fifteen-year-old Provider Tax Amendments but instead reflect a new and unjustifiably crabbed view of the federal government's role in contributing to public support of the Medicaid program.

The view that the federal government should only match expenditures financed through state and local tax revenues is not supported by Title XIX and runs contrary to decades of effort to make public providers less dependent on such revenues in carrying out their mission to serve the nation's most vulnerable citizens. We set forth below the relevant history that supports this conclusion. But it bears stressing at the outset that the approach now embraced by the proposed rules and their philosophical premise--that the non-federal share must derive from tax proceeds raised by governmental units--is, to use plain words, a bad idea. It limits the base of support for the Medicaid program by excluding worthy sources that can help to achieve the great and humane goal of assuring the widest availability of health care for the needy in our society. Nowhere in the preamble, or in its issuances or public statements on this subject over the past few years, has CMS or any of its representatives sought to justify the narrow view that underlies the proposed regulations as serving a public purpose or advancing the broad purposes of Medicaid. Why federal officials would want to adopt a view that limits the financial backing for such a critical and worthy program is hard to imagine.

The only justification ever offered by CMS is the assertion that the Medicaid program has always been predicated on state tax-funded contributions equal to the non-federal share of its costs. That is simply not the case. From its inception, Title XIX has contemplated that public entities not funded by state appropriations would contribute to the non-federal share of Medicaid expenditures. Section 1902(a)(2) permits a State plan to provide for local participation in as much as 60 percent of the non-federal share of total Medicaid expenditures, as

long as the lack of adequate "funds" from "local sources" does not result in lowering the amount, duration, scope or quality of care and services under the plan. There is no requirement in this section of the law that such "funds" come from tax revenues or that the "sources" be federally determined to be "units of government."

Section 1903(d)(1) of the Act, which also has been a feature of Title XIX from the program's inception, makes explicit Congress' intention that the non-federal share may encompass public funds derived from "other sources" than the State and its political subdivisions. That subsection contains reporting requirements in order for a State to seek federal financial participation ("FFP") for Medicaid expenditures, including

> stating the amount appropriated or *made available* by the State and its political subdivisions for such expenditures in such quarter, and if such amount is less than the State's proportionate share of the total sum of such estimated expenditures, *the source or sources from which the difference is expected to be derived. . . .*

42 U.S.C. § 1396b(d)(1) (emphasis added). This provision could not be more clear that sources of funds *in addition to* amounts appropriated by the State or its political subdivisions may supply the non-Federal match.

Those longstanding provisions are consistent with the fundamental purpose of Title XIX, in which Congress recognized that the "provision of medical care for the needy has long been a responsibility of the State and local public welfare agencies" and crafted a program in which the federal role would be to "assist[ ] the States and localities in carrying this responsibility by participating in the cost of care provided." H.R. Rep. No. 89-213, at 63 (1965). The statute thus guaranteed that "local funds could continue to be utilized to meet the non-Federal share of expenditures under the plan." H.R. Rep. No. 89-682 (1965) (Conf. Rep.)

Consistent with this intent and the scope of the statutory provisions, CMS and its predecessor agencies have long permitted public funds to be considered as the non-federal share

in claiming federal financial participation if the funds are appropriated directly to the State or local agency, *or* transferred from other "public agencies" to the State or local Medicaid agency, *or* are "certified by the contributing public agency as representing expenditures eligible for FFP under this section." 42 C.F.R. § 433.51(b).

CMS now asserts that it must substitute "units of government" for "public agencies" as the only entities qualified to put up the non-federal share through transfer or certification in order "to be consistent with" and "to conform the language to" Section 1903(w)(6)(A), which was added to Title XIX as part of the Provider Tax Amendments of 1991. 72 Fed. Reg. at 2240. The Provider Tax Amendments do not dictate or even suggest the result that CMS now seeks to achieve. Section 1903(w)(6)(A) is not a limitation on the nature of public entities contributing to the non-federal share of financial participation but instead a limitation on CMS's authority to regulate in this area. It states that notwithstanding any other provision:

> the Secretary may not restrict States' use of funds where such funds are derived from State or local taxes (or funds appropriated to State university teaching hospitals) transferred from or certified by units of government within a State as the non-Federal share of expenditures under this subchapter, regardless of whether the unit of government is also a health care provider. . . . .

The plain language of the provision ("the Secretary may not restrict . . .") makes clear that the Congress intended the provision merely to bar CMS from promulgating any regulation restricting States' use of the designated funds as participation in the non-federal share.

In its proposed rule, CMS takes the position that the restriction on the Secretary's authority to regulate certain funds means that only those funds are permissible sources of the state share and that all other funds are prohibited. Certain uncodified provisions of the 1992 Provider Tax Amendments rebut that interpretation. Section 5 of the 1992 law provides:

(a) *In general.* Subject to subsection (b), the Secretary of Health and Human Services shall issue such regulations (on an interim final or other basis) as may be necessary to implement this Act and the amendments made by this Act.

(b) *Regulations changing treatment of intergovernmental transfers.* The Secretary may not issue any interim final regulation that changes the treatment (specified in section 433.45(a) of title 42, Code of Federal Regulations) of public funds as a source of State share of financial participation under title XIX of the Social Security Act, except as may be necessary to permit the Secretary to deny Federal financial participation for public funds described in section 1903(w)(6)(A) of such Act (as added by section 2(a) of this Act) that are derived from donations or taxes that would not otherwise be recognized as the non-Federal share under section 1903(w) of such Act.

(c) *Consultation with States.* The Secretary shall consult with the States before issuing any regulations under this Act.

Pub. L. 102-234 § 5.

Section 5(b) would have been irrelevant and unnecessary if CMS were correct that "public funds" other than state and local tax revenue referred to in Section 1903(w)(6) were prohibited by the statutory amendments. In subsection (a), Congress had already instructed the Secretary to issue regulations "on an interim final or other basis" to implement the Act, and then specifically prohibited "any interim final regulation that changes the treatment . . . of public funds as a source of State share of financial participation" (except as necessary to implement the Act). If the use of any public funds other than state and local tax revenue was an unlawful donation – the position taken in the draft rule – then Section 5(b) of the provider tax law would serve no purpose. The inclusion of Section 5(b) in the Provider Tax Amendments also confirms that even though the existing language at 42 C.F.R. § 433.51(b) reflects a broader scope of "public funds" than "funds . . . derived from State or local taxes" (the standard of Section

1903(w)(6)(A)), the regulation is nonetheless a lawful interpretation of the governing Social Security Act provision, Section 1902(a)(2).

The legislative history of the Provider Tax Amendments also validates that Congress did not intend, through Section 1903(w)(6)(A), to narrow the standards set forth in Section 1902(a)(2) or in its implementing regulation (then located at 42 C.F.R. § 433.45, now at 42 C.F.R. § 433.51) for acceptable sources of the non-federal share. The House Conference Report on the final version of the legislation states:

> The conferees note that *current transfers from county or other local teaching hospitals continue to be permissible* if not derived from sources of revenue prohibited under this act. The conferees intend the provision of section 1903(w)(6)(A) to prohibit the Secretary from denying Federal financial participation for expenditures resulting from State use of funds referenced in that provision.

H.R. Conf. Rep. 102-409, at 18 (1991), *reprinted in* 1991 U.S.C.C.A.N. 1441, 1444 (emphasis added). No indication is given that the "current transfers" that continue to be permissible are only those derived from local tax revenue, as CMS asserts in the proposed rule.

CMS's own actions establish that the Provider Tax Amendments do not require it to limit acceptable "public funds" to those derived from tax revenue. In the regulations promulgated by the agency following the statute's enactment, the agency not only did not make the changes it now seeks to impose but expressly declined to do so, instead eliminating only the provision that had previously permitted private donations to be used toward the state share:

> Prior to the enactment of Public Law 102-234, regulations at 42 CFR 433.45 delineated acceptable sources of State financial participation. The major provision of that rule was that public and private donations could be used as a State's share of financial participation in the entire Medicaid program. As mentioned previously, **the statutory provisions of Public Law 102-234 do not include restrictions on the use of public funds** as the State share of financial participation. Therefore, the provisions of

> § 433.45 that apply to public funds as the State share of financial participation have been retained but redesignated as § 433.51 for consistency in the organization of the regulations.

57 Fed. Reg. 55118, 55119 (November 24, 1992) (emphasis added). The agency concluded that "until the Secretary adopts regulations changing the treatment of intergovernmental transfers, States may continue to use, as the State share of medical assistance expenditures, transferred or certified funds derived from any governmental source (other than impermissible taxes or donations derived at various parts of the State government or at the local level)." *Id.*

The Provider Tax Amendments and the contemporary regulatory history indicate that CMS does have the authority to "chang[e] the treatment" of public funds considered for the non-Federal share beyond what the statute expressly prohibits. But in order to do so CMS would have to demonstrate that its actions are reasonable and consistent with the statute (including Section 1902(a)'s reference to funds from "local sources"), and it may not simply assert, as it does here, that such a result is required by the plain meaning of Section 1903(w)(6): it is not. To the extent that CMS had concluded that some sources apart from taxes reflect abusive funding practices, it should target its rules to ending those practices, not simply claim *ipse dixit* that state and local tax revenues are the only permissible source of public funds.

Finally, even if CMS were correct that Section 1903(w)(6) permits only state and local tax revenue to be sources of the state match, the preamble to the proposed rule indicates that CMS intends to apply the rule in a manner inconsistent with that section's prohibition on the Secretary's ability to restrict the use of funds derived from State or local taxes. The preamble sets forth the view that State and local tax revenue is not eligible for use if "committed or earmarked for non-Medicaid activities." 72 Fed. Reg. at 2239. As an example of such an impermissible source of non-federal funding, CMS cites "[t]ax revenue that is contractually

obligated between a unit of State or local government and health care providers to provide indigent care." *Id.* There is no basis for such a restriction, and Section 1903(w)(6) explicitly states that the Secretary may *not* restrict any transfers or certifications "where such funds are derived from State or local taxes." In attempting to dictate what kind of tax revenue passes muster, CMS proposes to do the very thing prohibited by § 1903(w)(6)(A): restrict the use of funds derived from State or local taxes.

II. Defining a Unit of Government (Proposed § 433.50)

CMS proposes two definitions of the "units of government" whose funds can be considered as making up the non-Federal share of Medicaid expenditures. The first is a "State, a city, a county, a special purpose district, or other governmental unit in the State (including Indian tribes) that has generally applicable taxing authority." Proposed § 433.50(a)(1)(i). A health care provider will be considered to be a "unit of government" only if the provider itself has taxing authority or is "an integral part of a unit of government with taxing authority which is legally obligated to fund the health care provider's expenses, liabilities and deficits, so that a contractual arrangement with the State or local government is not the primary or sole basis for the health care provider to receive tax revenues." Proposed 42 C.F.R. § 433.50(a)(1)(ii)(A), (B). In the preamble, CMS asserts that a provider is likely not operated by a unit of government if an "independent entity [has] liability for the operation of the health care provider and will not have access to the unit of government's tax revenue without the express permission of the unit of government." 72 Fed. Reg. at 2240. Both aspects of the definition of "unit of government" are faulty and should not be adopted.

A. Comment on § 433.50(a)(1)(i)'s Requirement of "Generally Applicable Taxing Authority": Even assuming that CMS correctly asserts that under Section 1903(w)(6)(A) only "units of government" may participate in the non-federal share, it has defined "unit of

government" too narrowly. Section 1903(w)(7)(G) defines "unit of local government" as meaning "a State, a city, county, special purpose district, or other governmental unit in the State." CMS has added the requirement that, in order to be "governmental," the entity must have "generally applicable taxing authority." That requirement impermissibly narrows the "special purpose district" and "other governmental unit" components of the regulatory definition. CMS' rigid proposed definitions of "unit of government," and of what constitutes governmental "operation" of a provider, disregard States' inherent authority to create and to delegate functions to political subdivisions and agencies. In so doing, the proposed rules undercut the principle of federal-state cooperation embodied in the Medicaid program.

The requirement of taxing authority is not only an impermissible qualification to the definition in Section 1903(w)(7), but it is a qualification that is at odds with the recognition in Section 1903(w)(6) that a "unit of government" may be a "health care provider." Many, if not most, publicly owned or operated health care providers do not have taxing authority, and nonetheless have long been able to contribute to state Medicaid programs by using their funds as the non-federal share of Medicaid expenditures. Those contributions which have been used as acceptable "local sources" of funding would no longer be matchable under the proposed rule unless the State could establish that the provider was part of some other unit of government that had the requisite "generally applicable" taxing authority. That result not only eliminates a financial backbone of many public hospitals, but the attempt to have a federal agency define, in rulemaking, what constitutes a unit of state government flies in the face of the cooperative federalism on which the program is based.

By Executive Order binding on CMS, federal agencies must "closely examine the constitutional and statutory authority supporting any action that would limit the policymaking

discretion of the States and shall carefully assess the necessity for such action." Executive Order 13132, 64 Fed. Reg. at 43256 (August 4, 1999). Similarly, wherever feasible, agencies must "seek views of appropriate State, local and tribal officials before imposing regulatory requirements that might significantly or uniquely affect those governmental entities" and must "seek to minimize those burdens that uniquely or significantly affect such governmental entities, consistent with regulatory objectives." Executive Order 12866, Sec. 1(b)(9), as amended 58 Fed. Reg. 51735 (February 26, 2002). CMS has failed to respect those mandates here.

Few areas are as fundamental to the notion of state sovereignty as the ability to determine what constitutes a unit of government within the State. It is well established that "the state is supreme" in creating its political subdivisions and in defining their functions. *See Hunter v. City of Pittsburgh*, 207 U.S. 161, 179 (1907). States create political subdivisions, "counties, cities or whatever[,] . . . . 'as convenient agencies for exercising such of the governmental powers of the state as may be entrusted to them,' and the 'number, nature and duration of the powers conferred upon [political subdivisions] . . . rests in the absolute discretion of the state.'" *Reynolds v. Sims*, 377 U.S. 533, 575 (1964) (quoting *Hunter*, 207 U.S. at 178).

The power of taxation is only one of these powers. Taxing authority is not a precondition for an entity to be a unit of government. "Local government units do not have inherent power to tax because, in contrast to the state which creates them, they are viewed as subordinate units exercising only a delegated competence." JOHN MARTINEZ ET AL., LOCAL GOVERNMENT LAW § 23:2 (2006). Thus, while no one would doubt that a municipality is a unit of government, States frequently restrict, and may (absent State constitutional considerations) entirely suspend, municipalities' powers of taxation. CMS's requirement that a governmental entity must have "[g]enerally applicable taxing authority" in order to be considered a unit of

government whose funds may be used as the state share of Medicaid expenditures is thus adding a requirement that is not required by the Provider Tax Amendments and that fundamentally interferes with a State's own internal governmental structure.

The determination of what constitutes a "unit of government" is one that should be left to the States based on the broad definition in Section (w)(7) and CMS should omit taxing authority as a necessary precondition for unit of government status.[1]

B. Comment on § 433.50(a)(1)(ii)'s Definition of When a Health Care Provider is A Unit of Government. Section 1903(w)(6) recognizes that a "unit of government" can be a "health care provider" and yet CMS proposes a definition that is so limiting that some quintessentially public providers will be unable to meet it. According to the proposed rule, a provider must itself have "generally applicable taxing authority" or else demonstrate that it is an "integral part" of a governmental unit by showing that the government has an unconditional duty to fund the provider's operations expenses, losses, and deficits. If a provider does not meet this stringent definition it cannot certify its Medicaid expenditures for federal financial participation. This definition, too, imposes federal dictates on the organization of state government by administrative fiat, unsupported by the Provider Tax Amendments or any other provision of Title XIX.

Two classes of public providers would appear to be most adversely affected by the proposal. First, many public hospitals receive county, city, or State funding, but operate through autonomous hospital districts authorized by State law. Under these State laws, either the

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[1] For these reasons, the questionnaire developed by CMS and which was the subject of a Federal Register notice on January 19, 2007, should be discarded. Apart from its intrusiveness into the prerogative of states to determine the nature of their political subdivisions, the questionnaire is based on the same faulty premises as are the proposed rules.

city or county governing body, or voters, may authorize the creation of hospitals. The authorizing legislation invests the hospital with governmental status. State law typically empowers the city or county government, or the hospital district, to issue bonds or to impose special taxes to support the hospitals. State law frequently requires the governing board of the hospital to be elected by voters or appointed by government officials. State courts have held that these governing boards are public bodies, for example, subject to State open meeting requirements. *See Stegall v. Joint Twp. Dist. Memorial Hosp.*, 484 N.E.2d 1381, 1383 (Ohio App. 1985); *cf. Matagorda County Hosp. Dist. v. City of Palacios*, 47 S.W.3d 96, 100-101 (Tex. App. 2001) (city had standing to sue hospital district for failing to comply with open meeting requirements). Where (as frequently authorized by State law) a private entity manages the hospital, the government generally has the authority to terminate the lease or agreement for nonperformance.

While the municipal or county governments participating in a hospital district usually have some responsibility to provide financial support to the hospital, the municipality may, in order to encourage efficiency, provide a capped amount of financial support to the hospital, requiring it to absorb some losses and permitting it to enjoy profits. If the hospital authority administering the facility does not itself have "generally applicable taxing authority," then the operative question for public status, under the proposed rule, is whether the local government funds the hospital's expenses, losses, and deficits sufficiently for the hospital to be an "integral part" of local government. Hospitals operated under these systems have, until this rulemaking, been viewed as public hospitals. *See* 66 Fed. Reg. at 3154 (noting that facilities owned by "quasi-independent hospital districts" are non-State public hospitals).

Second, many public hospitals directly owned by States, cities, or State-chartered universities contract with private companies to manage some portion of the hospital business. CMS should not issue any rule that casts doubt on the ability of public hospitals to pursue this practice. Commonly, a State or local government or State university, while maintaining active involvement in the business operations of the hospital, may induce the contractor to improve efficiency by varying its payment to the contractor commensurate with the hospital's performance. In 2001, in response to comments, CMS's predecessor the Health Care Financing Administration ("HCFA") amended its proposed rule on upper payment limits ("UPL") in order to clarify in the final version that a hospital owned by a local government but managed by a private company was considered a non-State public facility. 66 Fed. Reg. at 3154. That approach is consistent with the Medicaid program history and purpose. CMS should continue to consider such a provider to be part of the unit of government as long as the governmental entity retains ultimate responsibility for the oversight and business operations of the provider.

There is no legal basis for CMS to require that the government fund all of a provider's losses, expenses, and liabilities, in order to acknowledge the provider as public. An analogy to State-local government relations demonstrates the flaw in this position: while no one questions that cities are governmental, State constitutional provisions frequently bar the State from lending its credit to a municipality, or at least limit the assistance the State may provide to the city. *See, e.g.*, N.Y. CONST. ART. 9, § 2(b)(2) (State may act in relation to property of a city government only by general law, by special request of two thirds of the legislature, or, except in the case of New York City, on a certificate of necessity issued by the Governor).

In the preamble to the proposed rule, CMS rejects the view that "an entity which is not governmental in nature but has a public-oriented mission (such as a not-for-profit hospital,

for example) may participate in the financing of the non-Federal share by CPEs." 72 Fed. Reg. at 2240. To the extent that the preamble indicates that not-for-profit status in and of itself is disqualifying as a unit of government (the rule is not clear on this point), the Commenting States disagree. Many traditional public providers are nonprofit corporations under Section 501(c)(3) of the Internal Revenue Code. These providers not only have a public-oriented mission but are subject to public oversight and receive substantial financial support from the communities in which they operate.

That an enterprise is organized in corporate form is not inconsistent with its being a public entity. Well-known examples of federal public entities that operate in corporate form include the Federal Deposit Insurance Corporation, the Tennessee Valley Authority, and the Communications Satellite Corporation. Frequently, State laws creating hospital districts allow the hospital to operate as a 501(c)(3) nonprofit corporation. Nonetheless, the authorizing legislation vests the hospital with governmental status. Hospitals operated under these hospital district laws have, until this rulemaking, been viewed as public hospitals. *See* 66 Fed. Reg. at 3154. Further, a CMS Medicare regulation governing whether a facility has provider-based status recognizes that a unit of State or local government may "formally grant[] governmental powers" to a health care provider organized as a public or nonprofit corporation. *See* 42 C.F.R. § 413.65(e)(3)(ii)(B).

Nonprofit corporations have many attributes of public entities. They are required to serve a "public interest," 26 C.F.R. § 1.501(c)(3)-1(d)(1)(ii). Unlike for-profit corporations, there are no shareholders, and no private persons can have any ownership interest in the nonprofit corporation. Nonprofit corporations can have "members" (though this is not required), but members have no ownership interest in the assets or business of the nonprofit corporation.

Further, when a nonprofit corporation terminates its operations, its assets must (depending on the applicable State law) be contributed either to another nonprofit or to the federal, State, or local government for a public purpose. In other words, once assets are committed to a benevolent purpose being carried out through a nonprofit corporation, those assets must remain available for a benevolent purpose.

Localities or hospital districts frequently choose to organize a hospital as a 501(c)(3) organization in order to ensure that the hospital will be able to accept private charitable donations. The Provider Tax Amendments do not bar a public provider or unit of government from receiving such donations, as long as the donor is not a provider. *See* 42 U.S.C. § 1396b(w)(2); *see also* 57 Fed. Reg. at 55120 (noting that States may continue to receive charitable donations from entities other than providers after the Provider Tax Amendments). The ability to receive private donations actually enhances the public mission of local hospitals, by strengthening their ability to fulfill their safety net function of treating the uninsured.

* * * * *

There is another way in which the proposed rules undermine the sound financing of the Medicaid program. There are many public entities that would not meet the restrictive "unit of government" definition proposed by CMS but that nonetheless receive financial support from counties or other governmental bodies. It is normal for such entities to share with their funding agencies any revenue received for their services, from private and public payors. Yet under the proposed rules this return of funds advanced to finance operations pending receipt of revenue would be considered impermissible donations, resulting in a reduction of the FFP otherwise payable to the State for Medicaid services provided by the public entity. (Remarkably, the preamble to the proposed rules acknowledges this consequence, apparently without

awareness that it would inhibit normal return of advanced funds by public bodies. See 72 Fed. Reg. at 2238).

This perverse consequence is entirely unwarranted and demonstrates how far out of kilter the proposed regulations are with the structure and intent of the Medicaid program. The Provider Tax provisions were carefully crafted to fit with the existing Medicaid program structure. Specifically, the donation provisions were aimed to private contributions of the non-federal share. They were never intended to prevent the kind of fund transfers described above.

III. Cost Limit for Providers Operated by Units of Government (Proposed § 447.206)

Proposed § 447.206(c)(1) provides that "[a]ll health care providers that are operated by units of government are limited to reimbursement not in excess of the individual provider's cost of providing covered Medicaid services to eligible Medicaid recipients." 72 Fed. Reg. 2246. Under proposed § 447.206(c)(2), the Secretary will determine "[r]easonable methods of identifying and allocating costs to Medicaid." *Id.* Proposed § 447.206(c)(3) and (c)(4) provide that for hospital and nursing facility (NF) services, "Medicaid costs must be supported using information based on the Medicare cost report," while for non-hospital and non-NF services, such costs "must be supported by auditable documentation in a form approved by the Secretary." *Id.* Under proposed § 447.206(d) and (e), each individual provider "must submit annually a cost report to the Medicaid agency that reflects [its] cost of serving Medicaid recipients during the year." *Id.* at 2246-47.

When States employ a cost-reimbursement methodology that is funded by certified public expenditures ("CPE"), they would be allowed to use the most recently filed cost reports to set interim rates and to trend these rates by a health-care-related index, and they would be required to perform interim and final reconciliations; as for payments made to providers operated by units of government that are not funded by CPEs, the Medicaid agency would have

to review each cost report "to determine that costs on the report were properly allocated to Medicaid," and it would have to "verify that Medicaid payments to the provider during the year did not exceed the provider's cost." *Id.* at 2247.

The proposed rule would eliminate existing § 447.271(b), which permits payments to "a public provider that provides services free or at a nominal charge at the same rate that would be used if the provider's charges were equal to or greater than its costs." *Id.* Section 447.272, which applies to ratesetting for inpatient services provided by hospitals, nursing facilities, and ICFs/MR, would be changed to provide that the UPL for all government operated facilities is "the individual provider's cost," and to provide that Medicaid payments to these facilities "must not exceed the individual provider's cost." *Id.* The same changes would be made to § 447.321's UPL rules for ratesetting for outpatient hospital and clinic services. *Id.*

Comment: CMS lacks the statutory authority to impose a cost limit on governmental providers, to require cost reporting by individual providers in support of this limit, and to change the UPL rules in order to implement this limit. Congress has rejected cost-based reimbursement and provider-specific limits, and it has done so for all providers, including those operated by units of government. The proposed rule represents a significant and unjustified departure from CMS's own earlier, better understandings of congressional intent. And by deleting the exception for nominal charge hospitals the proposal places in jeopardy those hospitals that are most committed to serving the poor and the uninsured.

1. Congress Has Rejected Cost-Based Reimbursement Principles. The history of Section 1902(a)(13) of the Social Security Act ("Act") clearly shows congressional rejection of cost-based reimbursement. When Congress first created Medicaid, Section 1902(a)(13) required States to pay the "reasonable cost" of inpatient hospital services. Pub. L.

No. 89-97, § 121(a) (1965). Ever since then, Congress has consistently given States ever greater flexibility in the design of payment methods for providers, both public and private.

In 1972, Congress amended the Act to permit States to develop their own methods and standards for reimbursement for inpatient hospital services, although the "reasonable cost" principle was retained. Pub. L. No. 92-603, § 232(a) (1972). At the same time, Congress provided that States were to pay for skilled nursing facility (SNF) and intermediate care facility (ICF) services "on a reasonable cost related basis"; again, States were permitted to develop their own methods and standards. *Id.* § 249(a). In a 1976 rulemaking implementing these changes, HCFA stated that prospective ratesetting "involve[s] payment rates not subject to further adjustment on the basis of the actual costs of a particular provider," that "the inherent cost containment potential of such limits negates the need for an additional ceiling," and that "there is no single figure that is the reasonable cost, but rather a spectrum of figures within an acceptable range, any one of which is a reasonable cost." 41 Fed. Reg. 27300, 27302-03 (July 1, 1976), *quoted in Ill. Dept. of Pub. Aid*, DAB No. 467 (1983); *see also* 46 Fed. Reg. 47964 (Sept. 30, 1981) (describing existing policy as permitting "profit . . . to facilities that can keep their costs below a prospectively determined . . . rate").

In 1980, Congress enacted the Boren Amendment, which further increased State flexibility in the reimbursement of SNFs and ICFs by deleting the "reasonable cost related basis" requirement for these facilities. States were now to pay for these facilities' services through the use of rates that were "determined in accordance with methods and standards developed by the State" and "which the State finds, and makes assurances . . . are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable" law. Pub. L. No. 96-499, § 962(a).

States were also required to "make[] further assurances . . . for the filing of uniform cost reports by each [SNF] or [ICF] and periodic audits by the State of such reports." *Id.* In 1981, Congress extended the Boren Amendment to hospitals. Pub. L. No. 97-35, § 2173 (1981).

It is plain from the legislative history of the Boren Amendment and its extension to hospitals that Congress intended States to have greater discretion in developing reimbursement mechanisms -- including the flexibility to set rates not subject to an actual cost limit and not subject to individual, provider-by-provider limits. There is no indication that this discretion was meant to be greater with respect to private providers than government providers. *See* H.R. Conf. Rep. No. 97-208, at 962 (1981); Sen. Rep. No. 97-139, at 744 (1981); H.R. Rep. No. 97-158, vol. II, at 292-93 (1981); H.R. Conf. Rep. No. 96-1479, at 154 (1980); Sen. Rep. No. 96-471, at 28-29 (1979). Moreover, in granting States greater rate-setting discretion, it is clear that Congress took a dim view of administrative overreaching in the form of unnecessary regulation and of paperwork requirements that overburdened States and facilities. *See* Sen. Rep. No. 97-139, at 744; Sen. Rep. No. 96-471, at 28-29.

In the preamble to interim final regulations implementing the Boren Amendment, HCFA recognized that "each State should be free to decide, in setting its payment rate, whether to allow facilities an opportunity for profit." 46 Fed. Reg. 47964 (Sept. 30, 1981). In a final rulemaking, HCFA further noted that Congress expected it to "develop regulations that would increase States' discretion in setting payment rates" and to "employ a Federal review process which would be less administratively burdensome." 48 Fed. Reg. 56046 (Dec. 19, 1983). HCFA declined to define the term "efficiently and economically operated facility," reasoning that doing so "would unnecessarily intrude upon the legislatively mandated flexibility provided to States." *Id.* HCFA also noted that the term "reasonable and adequate" is "not a precise

number, but rather a rate which falls within a range of what could be considered reasonable and adequate." *Id.*

In 1997, in response to court decision which had distorted the Congressional purpose by reading into the Boren Amendment cost based standards for rate setting and burdensome procedural prerequisites to state rate-setting, Congress repealed the Boren Amendment, eliminating the remaining constraints on State payment methods. In place of these limits Congress substituted only a public notice requirement. Pub. L. No. 105-33, Title IV, Subtitle H, Ch. 2, § 4711(a) (1997). Once again, Congress opted for broad state flexibility in establishing payment methods. *See* H.R. Conf. Rep. No. 105-217, at 867-68 (1997); H.R. Rep. No. 105-149, at 590-91 (1997); 143 Cong. Rec. S. 4000 (May 6, 1997). In sum, the history of Section 1902(a)(13), extending over a 32-year period, reflects a consistent movement by Congress away from cost-based limits provider reimbursement standards amounting to an affirmative rejection of a cost-based limit on payment rates.

2. Congress Has Rejected Provider-Specific Reimbursement Limits. The proposed rule ignores this history and purports to impose cost-based limits not only for institutional providers who would be subject to the provisions of Section 1902(a)(13) but all other providers as well, under the asserted authority of Section 1902(a)(30)(A) of the Act. That provision also does not supply the needed statutory authority for CMS's proposal. First, reading a cost limit into Section 1902(a)(30)(A) would be inconsistent with the congressional amendments to Section 1902(a)(13), which, as explained above, actually constitute a rejection of such a limit. Second, even if Section 1902(a)(30)(A) could be read in a vacuum, it could not fill the gap in statutory authority for imposing provider-specific limits on reimbursement. Contrary to the view expressed by CMS in the preamble to the proposed rule, 72 Fed. Reg. 2241, the

payment of prospective rates that are not adjusted to actual costs is wholly consistent with Section 1902(a)(30)(A)'s requirement that payments be consistent with efficiency and economy, and the history of that statutory provision as well reflects a movement away from provider-specific limits on reimbursement.

Section 1902(a)(30), like Section 1902(a)(13), has a history of congressional relaxation of constraints on State flexibility and of administrative recognition of that flexibility. Section 1902(a)(30), enacted in 1968, originally required States to "provide such methods and procedures relating to . . . the payment for . . . care and services available under the plan as may be necessary . . . to assure that payments . . . are not in excess of reasonable charges consistent with efficiency, economy, and quality of care." Pub. L. No. 90-248, § 237 (1968).

In 1981, as part of the same act in which the Boren Amendment was extended to hospitals under § 1902(a)(13), Congress amended § 1902(a)(30) by striking the original requirement that payment not be "in excess of reasonable charges." Pub. L. No. 97-35, § 2174 (1981). As a result, the provision simply required State Medicaid plans to provide methods ensuring that "payments are consistent with efficiency, economy, and quality of care."

This change was designed to "remove[] medicare reasonable charge levels as a ceiling on medicaid payments," thereby "remov[ing] the administrative burdens this requirement of current law imposes on the States and . . . provid[ing] States with the flexibility to create incentives to improve the availability and utilization of physician services under medicaid." H.R. Rep. No. 97-158, vol. II, at 312. Congress intended that States be permitted to "be more creative and offer incentives for improved delivery of care" and to "structure their physician payment levels to build in incentives or bonuses for physicians who provide care in more cost effective arrangements." *Id.* at 313. Congress also sought to "help simplify" State Medicaid

administration, and to ease "development of a Statewide medicaid fee schedule," both of which goals had been greatly hampered by the Medicare reasonable charge limit. *Id.* at 312-13.

In the preamble to interim final regulations implementing the 1981 amendment, HCFA noted that before the amendment, States had complained that "[t]he requirement for States to make and apply their own reasonable charge calculations and to obtain and use Medicare reasonable charge data imposed unjustified administrative costs and burdens on States," and that "[t]he Medicare reasonable charges vary from physician to physician, and from locality to locality," so that "[t]heir use as Medicaid payment limitations has resulted in the States being unable to apply a single payment rate Statewide unless that rate is set at or below the lowest Medicare reasonable charge level in the State." 46 Fed. Reg. 48556 (Oct. 1, 1981). HCFA recognized that Congress eliminated the reasonable charge limit "because it was aware of [these problems], and in recognition of States' need for flexibility in their Medicaid programs." *Id.* It noted that "*Congress expects the removal of the administrative burdens imposed on States by the prior law* to improve States' administration of their Medicaid programs and to provide States with the flexibility needed to create incentives to improve the availability and utilization of physicians services under Medicaid," and it responded by altering the regulations to "remove all references to reasonable charge limits for noninstitutional services under Medicaid." *Id.* (emphasis added).

After Congress eliminated the "reasonable charges" language of Section 1902(a)(30), the Medicare-based UPLs for institutional services were retained, but States were not required to apply the limit on a provider-by-provider basis. 46 Fed. Reg. 47964 (Sept. 30, 1981). States were free to apply the limit on an aggregate rather than facility-specific basis, "in keeping with the congressional intent that the calculation of the limit not be an administrative

burden on States"; they could proceed on the basis of estimates; and they were free to use prospective payment systems that employed "efficiency incentives or profit for providers to the extent they do not, or did not, incur costs in excess of the predetermined payment rate." 48 Fed. Reg. 56046 (Dec. 19, 1983).

Over time, concerns arose as to the level of payments to certain facilities, even though the overall aggregate UPL was not exceeded, *see* 51 Fed. Reg. 5728 (Feb. 18, 1986) (proposed rule), and in particular, that States were overpaying State-operated facilities, *see* 52 Fed. Reg. 28141 (July 28, 1987) (final rule). The regulations were refined so that the UPLs were to be calculated separately for State-operated facilities as well as for each group of facilities (hospitals, SNFs, ICFs, and ICFs/MR)as a whole. *Id.* A subsequent modification required that three categories of facilities -- State-owned or operated, non-State government-owned or operated, and privately owned and operated -- be considered separately. 66 Fed. Reg. 3148 (Jan. 12, 2001).

Importantly, however, the UPL rules continued to be easily applied: they were still based on estimates and still applied on an aggregate basis. 52 Fed. Reg. 28141. Indeed, HCFA expressly stated: "We considered facility-specific limitations as a possible remedy to the problem of excessive payments, but elected instead to refine our aggregate UPLs. We believe our approach provides an appropriate balance between the needs of States to have flexibility in rate setting and our objective to protect the integrity of the Medicaid program." 66 Fed. Reg. at 3152. HCFA stressed that it "want[ed] to curtail unnecessary spending in a way that results in the least amount of burden administratively on the States and the Federal government," 67 Fed. Reg. 2602, 2607 (Jan. 18, 2002), and it reiterated that it had considered and rejected facility-specific UPLs because of the administrative burdens of such a scheme, *id.* at 2610.

In light of this history, Section 1902(a)(30)(A) cannot support a rule barring all payments to government providers in excess of their individual, actual costs.

Decisions of the Departmental Appeals Board ("Board") additionally confirm the lack of authority for CMS to hold government providers to a different standard than the one to which it holds private providers, or to limit government providers to actual-cost reimbursement. The agency has tried to invoke OMB Circular A-87 as a basis for an actual-cost limit on payments to public providers, and the Board has rejected these efforts, holding that States may employ prospective payment systems without retroactive adjustment based on actual costs, even for public providers. The Board has explicitly held that "the cost principles [do] not impose an actual cost ceiling on claims for reimbursement for medical assistance provided by state-owned [facilities]," and that a State does not impermissibly profit where its claim for FFP is based on the cost it incurs in reimbursing facilities according to a prospective class rate. *Ill. Dept. of Pub. Aid*, DAB No. 467 (1983); *see also Alaska Dept. of Health & Soc. Servs.*, DAB No. 1452 (1993) (reiterating that "[a] distinguishing characteristic of prospective rate systems is that there needs to be no retrospective adjustment to reflect the actual costs of providing services during the rate period," and noting that under the "incentive theory" contemplated by the prospective payment regime, providers may retain profits designed to encourage cost-control or efficient operation).

The Board has stated, in a case concerning prospective payments made to State-operated ICFs/MR, that "the prospective rate is an estimate; the expectation is that it will not correspond precisely to the actual costs incurred during the rate year by any specific provider." *S.D. Dept. of Soc. Servs.*, DAB No. 934 (1988). The Board held that these rates were not subject to later adjustment based on actual costs, and it found no "unauthorized profit or windfall" where "the rates paid by the State met the Boren Amendment standard and . . . in all but one year costs

exceeded reimbursement." *Id.* The Board has also repeatedly distinguished the costs incurred by providers from the rates charged by providers to the State, and it has held that the latter are what form the basis of the State's claims for expenditures. *See Ala. Dept. of Human Res.*, DAB No. 1220 (1991); *N.J. Dept. of Human Servs.*, DAB No. 1016 (1989). It has also held that there can be an expenditure "even though the amount paid to the State-owned providers came back to the State treasury." *Fla. Dept. of Health and Rehab. Servs.*, DAB No. 884 (1987).

Finally, it bears mentioning that the present Administration has repeatedly asked Congress to impose a cost-limit on payments to public providers, putting CMS's new claim that it possesses the authority to do the same through its own regulatory initiative on shaky ground. That Congress has refused to legislate as requested highlights this lack of authority.

In addition to lacking a statutory basis, the proposed rule would create serious threats to the vitality of State programs for providing medical assistance. The proposed rule would remove the greatest incentive for cost savings by government providers. It would also drastically increase administrative burdens for both providers and the State -- burdens that threaten to cause many of the most important health care providers in the nation to cease participating in Medicaid altogether.

Limiting payments to each government provider's individual costs would eliminate these providers' incentive to keep costs below any prospectively set rate, since they would have to relinquish the difference. Indeed, a public provider, faced with a situation where it can never win and can only lose (when its costs exceed the prospectively set rate) is certain either to withdraw from providing Medicaid services or to demand that reimbursement at least be made more fair by reimbursing all actual costs, even if these costs exceed a prospectively set rate. The proposed rule will effectively force States to return to a system of retrospective cost

reimbursement -- precisely the "inherently inflationary" system whose lack of "incentives for efficient performance" motivated the Boren Amendment in the first place. Sen. Rep. No. 96-471, at 28 (1979). The return to cost-based reimbursement for public providers will permit them to break even at best, while permitting costs to spiral ever upwards, to the detriment of those who fund these costs -- States, the federal government, and taxpayers -- and those on whom these funds might otherwise have been spent.

Moreover, the proposed rule's cost reporting requirements dramatically increase the administrative burden on providers. Although some hospitals and NFs may already be accustomed to cost reporting, many other providers -- particularly those that are small or non-institutional -- are not. The effort and expense of keeping track of all the costs of providing Medicaid services, and especially of keeping track of time, will be enormously burdensome on many providers. The problem will be particularly acute with public schools, community mental health clinics, and other relatively small providers with very limited resources. These providers are generally paid on a fee-based system, which is relatively simply and cheaply administered. The cost-based recordkeeping and reporting required of these providers under the proposed rule would be difficult and in many cases impossible for them to manage. Indeed, many of these modestly sized but crucially important providers, when faced with the disproportionate administrative costs of the proposed rule, may simply find it no longer worthwhile or even possible to continue providing Medicaid services.

This will be particularly true of public schools, which are critical providers of health care services to children needing health care services related to their special education needs. The time studies and record keeping associated with proving the costs of providing health services may be outside the negotiated contracts of the therapists and other professionals who

work with children at risk, and the inability to prove costs may deprive schools of this needed source of funds.

Finally, the proposed rule will impose excessive administrative costs on the States. The requirements that States perform interim and final cost reconciliations and that they review and verify cost reports impose a staggering level of monitoring and paperwork on States. This sort of provider-by-provider review will overwhelm State Medicaid agencies' already overburdened staff and resources. By contrast, the current UPL calculations that the States perform are based on aggregate data and are relatively easy to do. The current UPL regime is straightforward and effective. It recognizes that payments should not be limitless -- a proposition that the Commenting States do not contest. There is no need, and no statutory authority, for the UPL rules to be stricter for government providers than for private ones, to be applied on a provider-specific basis, and for this basis to be actual cost.

In sum, the cost limit not only will not save money, it will waste it. State efforts to encourage cost-savings by public providers will be crippled by a return to cost-based reimbursement and inflated costs. Even if the cost limit could generate any savings on reimbursement, these savings would be offset by the massive administrative costs that will be incurred both by States and by those providers that continue to participate in the Medicaid system. And the Medicaid beneficiaries currently served by small providers unable to afford these administrative costs will be left with fewer -- or no -- sources of medical assistance.

3. The Nominal Charge Hospital Provision Should Be Retained

Current section 447.271 of the CMS regulations establishes a separate upper payment limit for inpatient hospital services at the level of the provider's "customary charges to the general public for the services." But it contains an exception for public providers that

provide services "free or at a nominal charge" to permit payment to the level that would be set "if the provider's charges were equal to or greater than its costs." The proposed changes would retain the general prohibition on payment above customary charges but would delete the exception for nominal charge hospitals.

The Commenting States urge that, whatever else is done, the nominal charge exception be retained. That exception recognizes that there are many hospitals that primarily serve the poor and uninsured that have established low charge levels for the benefit of those patients who are without coverage and would otherwise by hit with large bills for hospital services. A hospital ought not be prejudiced in its Medicaid reimbursement because it is willing to keep the cost of hospital care within reason for those who do not have coverage from insurance or public programs.

4. The Transition Provisions of the Current Regulations Should Be Retained

Current sections 447.272 and 447.321 of the CMS regulations embody the transition provisions mandated by Congress in the Medicare, Medicaid & SCHIP Benefit Improvement and Protection Act of 2000 ("BIPA"), Pub. L. 106-554, when it required CMS to amend its Upper Payment Limit rules to establish separate limits for three different categories of providers. The statutory provision provides for gradual reduction of the previous Upper Payment Limit over transition periods as long as eight years. The last of the transition periods will not expire until September 30, 2008.

There is no indication in the Preamble that CMS intended any interference with the transition provisions of BIPA that are still extant, and it could not by regulation affect the statutorily-prescribed periods. Nonetheless, to avoid confusion and to assure that the regulations

fully conform to the statute, any revision should retain the transition provisions at least until the longest of the transition periods has expired.

IV. Retention of Payments (Proposed § 447.207)

CMS proposes to add a new regulation at 42 C.F.R. § 447.207 that would require "all providers" to "receive and retain the full amount of the total computable payment provided to them," either as a state plan payment or under a waiver. To assure compliance, the Secretary would retain the right to examine "any associated transactions" related to the payment to ensure that the "claimed expenditure" is "equal to the State's net expenditure, and that the full amount of the non-Federal share of the payment has been satisfied." CMS justifies this proposed regulation as needed to "strengthen efforts to remove any potential for abuse involving the re-direction of Medicaid payments by IGTs." It states that compliance would be demonstrated by a showing that the funding source of an IGT is "clearly separated from the Medicaid payment" received by a provider, which would generally be the case if the IGT occurs before the payment and originates from an account funded by taxes that is separate from the account "in which the health care provider receives Medicaid payments."

Comment: This proposal promises to be a continuing source of mischief, and is a paradigm example of overkill, for it proposes to cope with a perceived problem that has been largely if not completely eliminated already with an intrusive new federal rule that will likely prove to be as difficult to apply as it is for the agency to define.

To begin with, the proposed rule amounts to a weapon directed at a non-existent problem. CMS justifies the proposal as necessary to deal with what it refers to as "redirection" of Medicaid payments, or what it has more commonly come to describe as "recycling." While there is no specific definition of this term, and it has been employed loosely in recent times to cover various practices, some of which are entirely appropriate, the rationale of the preamble

appears to be focused on situations where payments are made to public providers that are substantially beyond their needs and which are accompanied by transfers of all or most of the payment amount back to the state. CMS has addressed, and effectively eliminated that potential over the past several years, through amendment to its Upper Payment Rules in 2001 to require separate limits for state government owned and operated, non-state government owned and operated, and private owned and operated providers, and by policies employed in the state plan approval process that withhold approval for payments to providers in which more than the non-federal share is proposed to be transferred back to the state. By using the plan approval process to deal with perceived "recycling" issues, CMS has been able to distinguish between benign transfers that do not present issues of concern, and those that CMS believes present problems.

The proposed regulation, by contrast, is a blunderbuss approach that would strike at unobjectionable transfers that raise no "recycling" issues, but rather represent normal dealings between different entities within a state. For example, it is common for states, or their political subdivisions, to provide full funding to their health care providers, in the expectation of receiving the federal portion back from the provider when it has been reimbursed for serving Medicaid patients (just as the provider remits payment from other payors to its funding agency). Transfers from the provider to the funding agency out of Medicaid payments in such situations are not inappropriate; yet, the proposed rule would prohibit them.

As written, the rule is so absolute that it literally would prevent a provider from using Medicaid payments to pay normal operating expenses, such as taxes, fees, and costs of government-provided goods and services. While presumably this is not the intent of the rule, the fact that it has this effect demonstrates both that it is ill-conceived and that any attempt of this

kind to regulate how providers use their Medicaid reimbursement will create far more problems than it will solve.

There is no legal justification for the proposed payment retention regulation. The only authority cited in the preamble is section 1903(a)(1), which provides for the payment of FFP in state expenditures, and the provisions of Circular A-87 relating to "applicable credits." From these sources the preamble draws the conclusion that "failure by the provider to retain the full amount of reimbursement is inappropriate and inconsistent with statutory construction that the Federal government pay only its proportional cost for the delivery of Medicaid services" and that where the provider transfers a portion of the payment to another governmental entity the "net expenditure" is reduced so that FFP in the claimed expenditure results in the federal government paying more than the FMAP rate calculated in accordance with the statute. 72 Fed. Reg. at 2238.

Yet the same preamble discussion says that only where the governmental-operated provider transfer to the State "more than the non-Federal share" is there a situation where the net payment is "necessarily reduced." Id. This justification is not consistent with the provisions of the proposed rule that would preclude *any* transfer to the State from the payment received by the provider.

This inconsistency in rationale points up the absence of legal authority for the proposed regulation, for whether the prohibition is meant to apply to any portion of the Medicaid payment or only to the federal portion, it lacks a basis in the statute. No provider retains the entirety of a reimbursement payment. Given the reimbursement nature of Medicaid FFP, there could not be a valid prohibition on the provider returning to the original source of its outlays the portion of the payment so advanced. And if at the end of an accounting period a governmental

provider has experienced a surplus, its arrangement with a sponsoring governmental authority likely would require that the surplus be transferred to that authority. Nothing in the law would authorize CMS to proscribe any such transfers; yet that is what its proposed rule would do.

The proposed retention rule manages to sweep far too broadly while at the same time being unnecessary to deal with the one narrow situation that CMS says is the reason for the rule. The proposal should be withdrawn in its entirety.

V. Effect of the Proposed Rules on Demonstration Waivers (Preamble, page 2240)

The Preamble to the proposed rules states that "the provisions of this regulation" apply to all Medicaid payments (including disproportionate share hospital payments) "made under the authority of the State plan and under Medicaid waiver and demonstration authorities."[2]

Comment: Special mention is required of the preamble statement that the regulations will apply to demonstration waivers (including those under section 1115 of the Act), in light of assurances that have been provided to some state officials that the proposed rules would not affect their currently-outstanding 1115 waiver programs. Those assurances have appeared to be inconsistent not only with the preamble statement referred to above, but also with the terms and conditions of the waivers, which generally provide that the waiver program will be modified to conform to changes in applicable law and regulations.

The proposed regulations, were they to be adopted, promise to be very disruptive of existing waiver programs. Several states have made major commitments to funding arrangements authorized by 1115 waivers that rely, for example, on certification of expenditures by public entities that may not satisfy the extremely restrictive definitions in the proposed rules

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[2] There is an exception for the cost limit provision for Medicaid managed care organizations and SCHIP providers.

of those entitled to certify expenditures. Many utilize payment methodologies for providers, including public providers, that are not necessarily confined to the providers' costs. There are approved waiver programs that embody expected transfers by providers of portions of the payments received. And it is common for these programs, as for Medicaid programs generally, to rely on sources other than state and local taxes to provide the non-federal share of expenditures.

Thus, were the proposed rules to be adopted, they would seriously impair the viability of 1115 waiver programs currently in place. Moreover, because these programs are all subject to time-limited authorizations, requiring periodic renewal, states with such waivers would have no assurance that they would obtain renewal of their programs, no matter how successful, without complying with the proposed regulations, which could well undermine the entire basis for the waiver program.

Demonstration waivers have proved themselves to be a vital and worthwhile aspect of the Medicaid program, and have been a prime source for testing new ways for delivering services and financing the program. The continued success of this avenue for innovation depends on opportunity to escape from programmatic requirements that can stifle initiative and block improvements. Nothing would more undermine the effectiveness of this excellent means of implementing program change than to impose new and restrictive financing rules on projects after they have been developed, reviewed, approved and initiated.

While the Commenting States firmly believe that the entire rulemaking proposal is ill-conceived and should be abandoned, at the very least the rules should expressly be made inapplicable to any currently-operating demonstration program under section 1115, for as long as that program remains in effect, including through subsequent renewal periods.

Conclusion

The proposed rules are not necessary to deal with any perceived imperfections in or unanticipated effects of the current method of financing the Medicaid program throughout the states. Rather, they represent a reversal of the way in which Medicaid has been financed from the time of the program's inception through repeated Congressional review and amendment over the past 40 years. If adopted, they would force substantial disruption of the program and would surely lead to a reduction in resources available to support the delivery of basic health care to those the Medicaid program was intended to serve.

A proposal with these characteristics is not worthy of serious consideration. The Commenting States urge CMS to abandon it, and to disavow the unsupportable premises on which it is predicated.

Respectfully submitted,

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On behalf of the States of Alaska, Connecticut, Illinois, Louisiana, Maine, Maryland, Michigan, Missouri, New Hampshire, New Jersey, North Carolina, Oklahoma, Pennsylvania, Tennessee, Utah, Washington and Wisconsin

March 19, 2007

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JUN 2 2 2007

Centers for Medicare and Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, Maryland 21244-8016
Attention: CMS-2279-P

Dear Sir or Madam:

The Commonwealth of Pennsylvania, Department of Public Welfare, Office of Medical Assistance Programs (OMAP) is submitting comments on the Centers for Medicare and Medicaid Services (CMS) proposed rule entitled "Medicaid Program; Graduate Medical Education," published in the Federal Register, Volume 72, Number 99, Pages 28930-28936, on May 23, 2007.

Pennsylvania is concerned that adoption of this rule could compromise access to care for our most vulnerable citizens and for this reason, we oppose it. Teaching hospitals deliver a significant share of the inpatient medical care provided to Medical Assistance (MA) consumers in the Commonwealth, particularly in the urban markets of Philadelphia and Pittsburgh. Maintaining the high level of program participation by these institutions is essential to effective operation of our MA Program. Given the tight budgetary climate in Pennsylvania and nationwide, state MA programs and providers alike rely on all funding sources to maintain an adequate availability of hospital services. Graduate medical education (GME) payments supplement the MA rates for our teaching hospitals, reimbursing these institutions for the added costs associated with residency training programs. Absent this funding source, hospitals will be increasingly hard-pressed to serve the MA population.

Furthermore, funding of GME promotes the delivery of quality medical care. A comprehensive review of literature demonstrated the quality of care provided at teaching institutions in treating a range of complex conditions prevalent among the poor and elderly.[1] Pennsylvania, like most other states, is actively engaged in efforts to improve the quality of care provided to our Medical Assistance consumers and we rely on the expertise of teaching hospitals as part of this endeavor.

[1] "Quality of Care in Teaching Hospitals," by Dr. Joel Kupersmith for the Association of American Medical Colleges, 2003

Nothing in the care plan shall require an individual to utilize all of the waiver or other Medicaid state plan services authorized in the plan.

The plan must contain an attestation at the beginning and end of each planning period that the individual declines services.

No payment shall be made for targeted case management services for any individual to any provider of such services if the case file for such individual fails to fully meet the requirements in this subsection (c).

No individual may receive more than one type of targeted case management service at the same time.

Iowa Policy and Practice

- Documentation requirements are in 441 IAC- Chapter 79 and other program-specific chapters.

Changes Required

- Revise all case management rules for compliance with these regulations.

Changes that May Be Required

- None identified

Issues to Be Discussed with CMS Regional Office

- None identified

Target Group

EPSDT- Age 0-21 Administration
Age 3-21 Disabled Children-Eliminated
Maternal health population Administrative Contracting

No longer under TCM. Closing out of State plan

Target Group
Age 0-3 Disabled Children

Service Financing

Financed at 63% federal match and 37% state match.

Provider Qualifications

Current

- Audiologists-licensed or certified
- Early childhood – special education
- Nurse – licensed
- Dietitian – licensed
- Occupational therapist-licensed
- Occupational therapist assistant-licensed
- Orientation and mobility specialist
- Physical therapist-licensed
- Physical therapist assistant – licensed
- Psychologist-licensed
- Speech language pathologist –licensed or certified
- Social worker – licensed
- Physician - licensed

New
Include current providers. Expand to include Targeted Case Management under the State Plan and DHS Service workers

Reimbursement

Current
Fee Schedule - 15-minute unit
Fee Schedule - Home visit unit
New

15-minute units. Time is totaled at the end of the month.
COST BASED?

Issues arising under the Federal Rules and Guidance

- Guidance at 72 FR 68080 in paragraph 2 of section entitled "A. Freedom of Choice Exception to Permit Limitation of Case Management Providers for Certain Target Groups – 431.51(c)
- Interim rules effective 3/3/08.
- Change in the unit of payment- rate rebasing on different cost allocation
- Documentation requirements clarified
- Monitoring activities clarified
- Requirement for comprehensive assessment and care plan defined.
- Document whether the individual has declined services in the care plan.
- Case Management cannot be a gatekeeper to authorize or deny services in the plan.
- Individuals transitioning out of long term institutional stay that is longer than 180 consecutive days may receive case management 60 consecutive days prior to moving out of institution.
- Individuals transitioning out of long term institutional stay that is less than 180 consecutive days may receive case management during the last 14 days prior to discharge.
- Not compel an individual to receive Case Management services as a condition of receiving other Medicaid services.

State Policy Issues

- Implementing changes by 3/3/08 including rules, waiver amendment, manuals and payment system changes.
- Determine the methodology for payment including cost reporting.
- The reimbursement regulations and methodology will require rule changes and waiver amendments.
- Determine if monitoring activities are sufficient
- Determine if current rules meet requirement for comprehensive assessment and care plan.
- Clarify how the service plan documentation must be completed when consumer declines services.
- Determine what changes (if any) are needed for authorization and denial of services.
- Determine if payment for case management for individuals living in institution will be applicable (60 or14 days of CM)
- CMS requires case coordination with HCBS waivers. Clarify whether the care coordination is still required by specific entities for HCBS waivers and if not what the alternatives will be.
- Determine if there will be several TCM groups within the 0-3 population i.e. one HCBS waiver and Individual Family Service Plan (IFSP) or IFSP only.

- Determine responsibilities under Medicaid and IDEA as required by federal regulation including case file content.
- Change TCM State Plan and HCBS waivers (MR, BI, I&H) to add IFSP case management as a provider type and designate one case manager.
- Cross training TCM and IFSP case managers on HCBS and IDEA requirements.
- Evaluate capacity to determine is there is sufficient access to case management.

Target Group

HCBS Elderly Waiver – Age 65 and older

Service Financing

Elderly case management is a Home and Community Based Service. Financed at 63% federal match and 37% state match.

Provider Qualifications

Current

a. The case management provider organization shall be an agency or individual that:
(1) Is accredited by the mental health, mental retardation, developmental disabilities, and brain injury commission as meeting the standards for case management services in 441—Chapter 24; or
(2) Is accredited through the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) to provide case management; or
(3) Is accredited through the Council on Accreditation of Rehabilitation Facilities (CARF) to provide case management; or
(4) Is accredited through the Council on Quality and Leadership in Supports for People with Disabilities (The Council) to provide case management; or
(5) Is approved by the department of elder affairs as meeting the standards for case management services in 321—Chapter 21; or
(6) Is approved by the department of public health as meeting the standards for case management services in 641—Chapter 80.

New

Same as Current

Reimbursement

Current

Upper limit of $70.00 per month (unit)

New

15-minute units. Time is totaled at the end of the month.
COST BASED?

Issues arising under the Federal Rules and Guidance

- Guidance at 72 FR 68080 in paragraph 2 of section entitled "A. Freedom of Choice Exception to Permit Limitation of Case Management Providers for Certain Target Groups – 431.51(c)
- Interim rules effective 3/3/08.
- Change in the unit of payment
- Documentation requirements clarified
- Monitoring activities clarified
- Requirement for comprehensive assessment and care plan defined.
- Document whether the individual has declined services in the care plan.
- Case Management cannot be a gatekeeper to authorize or deny services in the plan.
- Individuals transitioning out of long term institutional stay that is longer than 180 consecutive days may receive case management 60 consecutive days prior to moving out of institution.
- Individuals transitioning out of long term institutional stay that is less than 180 consecutive days may receive case management during the last 14 days prior to discharge.
- Not compel an individual to receive Case Management services as a condition of receiving other Medicaid services.

State Policy Issues

- Implementing changes by 3/3/08 including rules, waiver amendment, manuals and payment system changes.
- Determine the methodology for payment including cost reporting.
- The reimbursement regulations and methodology will require rule changes and waiver amendments.
- Determine if monitoring activities are sufficient
- Determine if current rules meet requirement for comprehensive assessment and care plan.
- Clarify how the service plan documentation must be completed when consumer declines services.
- Determine what changes (if any) are needed for authorization and denial of services.
- Determine if payment for case management for individuals living in institution will be applicable (60 or14 days of CM)

- CMS requires case coordination with HCBS waivers. Clarify whether the care coordination is still required by specific entities for HCBS waivers and if not what Implementing changes by 3/3/08 including rules, waiver amendment, manuals and payment system changes.
- Determine the methodology for payment including cost reporting. Currently legislation limits to average rate and maximum aggregate amount for EW case management.
- The reimbursement regulations and methodology will require rule changes and waiver amendments.
- Determine if monitoring activities are sufficient
- Determine if current rules meet requirement for comprehensive assessment and care plan.
- Clarify how the service plan documentation must be completed when consumer declines services.
- Determine what changes (if any) are needed for authorization and denial of services.
- Determine if payment for case management for individuals living in institution will be applicable (60 or14 days of CM)
- CMS requires case coordination with HCBS waivers. Clarify whether the care coordination is still required by specific entities for HCBS waivers and if not what the alternatives will be.
- Determine whether collateral contacts should be required for HCBS service coordination.

Target Group

HCBS Seriously Emotionally Disturbed Children - Age 0-17

Service Financing

1115 CMS Demonstration waiver operating as a CMS 1915c waiver. Financed at 63% federal match and 37% state match.

Provider Qualifications

Current

Must meet Iowa Administrative Code, 441-Chapter 24 Standards.
"Qualified case managers and supervisors" means people who have the following qualifications:

1. A bachelor's degree with 30 semester hours or equivalent quarter hours in a human services field (including, but not limited to, psychology, social work, mental health counseling, marriage and family therapy, nursing, education, occupational therapy, and recreational therapy) and at least one year of experience in the delivery of services to the population groups that the person is hired as a case manager or case management supervisor to serve; or
2. An Iowa license to practice as a registered nurse and at least three years of experience in the delivery of services to the population group the person is hired as a case manager or case management supervisor to serve.
People employed as case management supervisors on or before August 1, 1993, who do not meet these requirements shall be considered to meet these requirements as long as they are continuously employed by the same case management provider.

New

Same as Current

Reimbursement

Current

Monthly fee for service with cost settlement. Providers of MR/CMI/DD case management services are reimbursed on the basis of a payment for a month's provision of service for each client enrolled in an MR/CMI/DD case management program for any portion of the month based on reasonable and proper costs for service provision. The fee will be determined by the department with advice and consultation from the appropriate professional group and will reflect the amount of resources involved in service provision. Monthly fee for service with cost settlement. Retrospective cost-settled rate.

New

15-minute units. Time is totaled at the end of the month.
COST BASED?

Issues arising under the Federal Rules and Guidance

- Guidance at 72 FR 68080 in paragraph 2 of section entitled "A. Freedom of Choice Exception to Permit Limitation of Case Management Providers for Certain Target Groups – 431.51(c) - Freedom of Choice of providers by qualified provider or Guidance at 73 FR 68092 in paragraph 2 of section entitled "Case Management Services" allowing freedom of choice by specific geographic area.
- Interim rules effective 3/3/08.
- Change in the unit of payment
- Documentation requirements clarified
- Monitoring individual service plan clarified
- Requirement for comprehensive assessment and care plan defined.
- Document whether the individual has declined services in the care plan.

- Case Management cannot be a gatekeeper to authorize or deny services in the plan.
- Individuals transitioning out of long term institutional stay that is longer than 180 consecutive days may receive case management 60 consecutive days prior to moving out of institution.
- Individuals transitioning out of long term institutional stay that is less than 180 consecutive days may receive case management during the last 14 days prior to discharge.
- Not compel an individual to receive Case Management services as a condition of receiving other Medicaid services.

State Policy Issues

- State Plan Case Management funded under medical assistance shall be provided by the department except when a county or a consortium of counties contracts with the department to provide the services. A county or consortium of counties may contract to be the provider at any time and the department shall agree to the contract so long as the contract meets the standards for case management adopted by the department. The county or consortium of counties may subcontract for the provision of case management services so long as the subcontract meets the same standards. A county board of supervisors may change the provider of individual case management services at any time. If the current or proposed contract is with the department, the county board of supervisors shall provide written notification of a change at least ninety days before the date the change will take effect. Is the provision in Iowa Code restricting case management to counties still permissible?
- Implementing changes by 3/3/08 including rules, waiver amendment, manuals payment system changes.
- Determine the methodology for payment including cost reporting.
- The reimbursement regulations and methodology will require rule changes and waiver amendments.
- Determine if monitoring individual service plan clarified
- Determine if current rules meet requirement for comprehensive assessment and care plan.
- Clarify how the service plan documentation must be completed when consumer declines services.
- Determine what changes (if any) are needed for authorization and denial of services.
- Determine if payment for case management for individuals living in institution will be applicable (60 or14 days of CM)
- CMS requires case coordination with HCBS waivers. Clarify whether the care coordination is still required by specific entities for HCBS waivers and if not what the alternatives will be.

Target Group

HCBS AIDS HIV-all ages

Service Financing

Aids/HIV service coordination is a requirement for all HBCS waiver programs. Financed at the Administrative activity rate 50% state and 50% federal match.

Provider Qualifications

Current

Department of Human Services Service Worker-must meet State requirements

New

Same as current

Reimbursement

Current

Medicaid Administrative Activity match no per diem reimbursement.

New

Same as current

Issues arising under the Federal Rules and Guidance

- Guidance at 72 FR 68080 in paragraph 2 of section entitled "A. Freedom of Choice Exception to Permit Limitation of Case Management Providers for Certain Target Groups – 431.51(c) - Freedom of Choice of providers by qualified provider or Guidance at 73 FR 68092 in paragraph 2 of section entitled "Case Management Services" allowing freedom of choice by specific geographic area.
- Interim rules effective 3/3/08.
- Change in the unit of payment
- Documentation requirements clarified
- Monitoring individual service plan clarified
- Requirement for comprehensive assessment and care plan defined.
- Document whether the individual has declined services in the care plan.
- Case Management cannot be a gatekeeper to authorize or deny services in the plan.

State Policy Issues

- Case management is provided as administrative activities (50-50% state/federal match)-determine if the current CMS rules are required for Administrative activities.
- Implementing changes by 3/3/08 including rules, waiver amendment, manuals payment system changes if applicable.
- Does the 15 minute increment apply to service coordination under Administrative activities.
- Determine if monitoring individual service plan is applicable.
- Determine if current rules meet requirement for comprehensive assessment and care plan.
- Clarify how the service plan documentation must be completed when consumer declines services.
- Determine what changes (if any) are needed for authorization and denial of services.
- Determine if payment for case management for individuals living in institution will be applicable (60 or14 days of CM)
- CMS requires case coordination with HCBS waivers. Clarify whether the care coordination is still required by specific entities for HCBS waivers and if not what the alternatives will be.
- Not compel an individual to receive Case Management services as a condition of receiving other Medicaid services.
- Determine whether collateral contacts should be required for HCBS service coordination.

Target Group

HCBS Physical Disability-Age 18 and older

Service Financing

HCBS Physical Disability service coordination is a requirement for all HBCS waiver programs. Financed at the Administrative activity rate 50% state and 50% federal match.

Provider Qualifications

Current

Department of Human Services Service Worker-must meet State requirements

New

Same as current

Reimbursement

Current

Medicaid Administrative Activity match no per diem reimbursement.

New

Same as current

Issues arising under the Federal Rules and Guidance

- Guidance at 72 FR 68080 in paragraph 2 of section entitled "A. Freedom of Choice Exception to Permit Limitation of Case Management Providers for Certain Target Groups – 431.51(c) - Freedom of Choice of providers by qualified provider or Guidance at 73 FR 68092 in paragraph 2 of section entitled "Case Management Services" allowing freedom of choice by specific geographic area.
- Interim rules effective 3/3/08.
- Change in the unit of payment
- Documentation requirements clarified
- Monitoring individual service plan clarified
- Requirement for comprehensive assessment and care plan defined.
- Document whether the individual has declined services in the care plan.
- Case Management cannot be a gatekeeper to authorize or deny services in the plan.

State Policy Issues

- Case management is provided as administrative activities (50-50% state/federal match)-determine if the current CMS rules are required for Administrative activities.
- Implementing changes by 3/3/08 including rules, waiver amendment, manuals payment system changes if applicable.
- Does the 15-minute increment apply to service coordination under Administrative activities?
- Determine if monitoring individual service plan is applicable.
- Determine if current rules meet requirement for comprehensive assessment and care plan.
- Clarify how the service plan documentation must be completed when consumer declines services.
- Determine what changes (if any) are needed for authorization and denial of services.
- Determine if payment for case management for individuals living in institution will be applicable (60 or14 days of CM)
- CMS requires case coordination with HCBS waivers. Clarify whether the care coordination is still required by specific entities for HCBS waivers and if not what the alternatives will be.

- Not compel an individual to receive Case Management services as a condition of receiving other Medicaid services.
- Determine whether collateral contacts should be required for HCBS service coordination.

Target Group

HCBS Ill & Handicapped – Age 0-64
SSI Disabled – Age 21 to 25

Service Financing

HCBS Ill & Handicapped service coordination is a requirement for all HBCS waiver programs. Financed at the Administrative activity rate 50% state and 50% federal match.

Provider Qualifications

Current

Department of Human Services Service Worker-must meet State requirements

New

Same as current

Reimbursement

Current

Medicaid Administrative Activity match no per diem reimbursement.

New

Same as current

Issues arising under the Federal Rules and Guidance

- Guidance at 72 FR 68080 in paragraph 2 of section entitled "A. Freedom of Choice Exception to Permit Limitation of Case Management Providers for Certain Target Groups – 431.51(c) - Freedom of Choice of providers by qualified provider or Guidance at 73 FR 68092 in paragraph 2 of section entitled "Case Management Services" allowing freedom of choice by specific geographic area.
- Interim rules effective 3/3/08.
- Change in the unit of payment

- Documentation requirements clarified
- Monitoring individual service plan clarified
- Requirement for comprehensive assessment and care plan defined.
- Document whether the individual has declined services in the care plan.
- Case Management cannot be a gatekeeper to authorize or deny services in the plan.

State Policy Issues

- Case management is provided as administrative activities (50-50% state/federal match)-determine if the current CMS rules are required for Administrative activities.
- Implementing changes by 3/3/08 including rules, waiver amendment, manuals payment system changes if applicable.
- Does the 15-minute increment apply to service coordination under Administrative activities?
- Determine if monitoring individual service plan is applicable.
- Determine if current rules meet requirement for comprehensive assessment and care plan.
- Clarify how the service plan documentation must be completed when consumer declines services.
- Determine what changes (if any) are needed for authorization and denial of services.
- Determine if payment for case management for individuals living in institution will be applicable (60 or14 days of CM)
- CMS requires case coordination with HCBS waivers. Clarify whether the care coordination is still required by specific entities for HCBS waivers and if not what the alternatives will be.
- Not compel an individual to receive Case Management services as a condition of receiving other Medicaid services.
- Determine whether collateral contacts should be required for HCBS service coordination.

Target Group

HCBS Brain Injury – Age 18 and older with injury occurring after age 18 (not considered DD)

Service Financing

HCBS Brain Injury Case management is a Home and Community Based Service. Financed at 63% federal match and 37% state match.

Provider Qualifications

Current

Case management provider organizations are eligible to participate in the Medicaid HCBS brain injury waiver program provided that they meet the standards in 441—Chapter 24 and they are the department of human services, a county or consortium of counties, or a provider under subcontract to the department or a county or consortium of counties.

New

Same as Current

Reimbursement

Current

Fee schedule not to exceed $572.75 per month.

New

15-minute units. Time is totaled at the end of the month.

Issues arising under the Federal Rules and Guidance

- Guidance at 72 FR 68080 in paragraph 2 of section entitled "A. Freedom of Choice Exception to Permit Limitation of Case Management Providers for Certain Target Groups – 431.51(c)
- Interim rules effective 3/3/08.
- Change in the unit of payment
- Documentation requirements clarified
- Monitoring activities clarified
- Requirement for comprehensive assessment and care plan defined.
- Document whether the individual has declined services in the care plan.
- Case Management cannot be a gatekeeper to authorize or deny services in the plan.
- Individuals transitioning out of long term institutional stay that is longer than 180 consecutive days may receive case management 60 consecutive days prior to moving out of institution.
- Individuals transitioning out of long term institutional stay that is less than 180 consecutive days may receive case management during the last 14 days prior to discharge.
- Not compel an individual to receive Case Management services as a condition of receiving other Medicaid services.

State Policy Issues

- Implementing changes by 3/3/08 including rules, waiver amendment, manuals and payment system changes.
- Determine the methodology for payment including cost reporting.
- The reimbursement regulations and methodology will require rule changes and waiver amendments.
- Determine if monitoring activities are sufficient
- Determine if current rules meet requirement for comprehensive assessment and care plan.
- Clarify how the service plan documentation must be completed when consumer declines services.
- Determine what changes (if any) are needed for authorization and denial of services.
- Determine if payment for case management for individuals living in institution will be applicable (60 or14 days of CM)
- CMS requires case coordination with HCBS waivers. Clarify whether the care coordination is still required by specific entities for HCBS waivers and if not what the alternatives will be.
-

Target Group

Brain Injury – Age 18 and older with injury occurring prior to age 18 (considered DD)
Chronically Mentally Ill- Age 18 and older
Managed Care – Age 18 and older
Habilitation – Any age
Mental Retardation children – Age 0-17
Mental Retardation Adults- 18 and over

Service Financing

State Plan Targeted Case Management service financed at 63% federal match and 37% state match.

Provider Qualifications

Current

Must meet Iowa Administrative Code, 441-Chapter 24 Standards.

"Qualified case managers and supervisors" mean people who have the following qualifications:

1. A bachelor's degree with 30 semester hours or equivalent quarter hours in a human services field (including, but not limited to, psychology, social work, mental health counseling, marriage and family therapy, nursing, education, occupational therapy, and recreational therapy) and at least one year of experience

in the delivery of services to the population groups that the person is hired as a case manager or case management supervisor to serve; or
2. An Iowa license to practice as a registered nurse and at least three years of experience in the delivery of services to the population group the person is hired as a case manager or case management supervisor to serve.
People employed as case management supervisors on or before August 1, 1993, who do not meet these requirements shall be considered to meet these requirements as long as they are continuously employed by the same case management provider.

New

Same as Current

Reimbursement

Current

Monthly fee for service with cost settlement. Providers of MR/CMI/DD case management services are reimbursed on the basis of a payment for a month's provision of service for each client enrolled in an MR/CMI/DD case management program for any portion of the month based on reasonable and proper costs for service provision. The fee will be determined by the department with advice and consultation from the appropriate professional group and will reflect the amount of resources involved in service provision. Monthly fee for service with cost settlement. Retrospective cost-settled rate.

New
15-minute units. Time is totaled at the end of the month.
COST BASED?

Issues arising under the Federal Rules and Guidance

- Guidance at 72 FR 68080 in paragraph 2 of section entitled "A. Freedom of Choice Exception to Permit Limitation of Case Management Providers for Certain Target Groups – 431.51(c) - Freedom of Choice of providers by qualified provider or Guidance at 73 FR 68092 in paragraph 2 of section entitled "Case Management Services" allowing freedom of choice by specific geographic area.
- Interim rules effective 3/3/08.
- Change in the unit of payment
- Documentation requirements clarified
- Monitoring individual service plan clarified
- Requirement for comprehensive assessment and care plan defined.
- Document whether the individual has declined services in the care plan.
- Case Management cannot be a gatekeeper to authorize or deny services in the plan.

- Individuals transitioning out of long term institutional stay that is longer than 180 consecutive days may receive case management 60 consecutive days prior to moving out of institution.
- Individuals transitioning out of long term institutional stay that is less than 180 consecutive days may receive case management during the last 14 days prior to discharge.
- Not compel an individual to receive Case Management services as a condition of receiving other Medicaid services.

State Policy Issues

- State Plan Case Management funded under medical assistance shall be provided by the department except when a county or a consortium of counties contracts with the department to provide the services. A county or consortium of counties may contract to be the provider at any time and the department shall agree to the contract so long as the contract meets the standards for case management adopted by the department. The county or consortium of counties may subcontract for the provision of case management services so long as the subcontract meets the same standards. A county board of supervisors may change the provider of individual case management services at any time. If the current or proposed contract is with the department, the county board of supervisors shall provide written notification of a change at least ninety days before the date the change will take effect. Is the provision in Iowa Code restricting case management to counties still permissible?
- Implementing changes by 3/3/08 including rules, waiver amendment, manuals payment system changes.
- Determine the methodology for payment including cost reporting.
- The reimbursement regulations and methodology will require rule changes and waiver amendments.
- Determine if monitoring individual service plan clarified
- Current rules meet requirement for comprehensive assessment and care plan. Train TCM's to assure compliance with rules.
- Clarify how the service plan documentation must be completed when consumer declines services.
- Determine what changes (if any) are needed for authorization and denial of services.
- Determine if payment for case management for individuals living in institution will be applicable (60 or14 days of CM)
- CMS requires case coordination with HCBS waivers. Clarify whether the care coordination is still required by specific entities for HCBS waivers and if not what the alternatives will be.

Questions on CMS TCM Interim Final Rule
January 24, 2008
Kansas City Regional Office

GENERAL

1. The interim rule includes guidance that goes beyond the rule. Are States going to be held to the guidance or the rule?

2. To which Iowa case management services do these interim rules apply?
   - TCM State Plan Services for MR/DD/CMI adult population
   - TCM services for children in the SED 1115 waiver population (currently in the State Plan group). Are there any issues with this?
   - Age 0-3 Disabled children
   - Age 3-21 Disabled children
   - EPSDT
   - Pregnant Women
   - TCM services as a HCBS waiver service (BI & Elderly)
   - CM under HCBS waivers where DHS Service Workers provide the service currently claims an administrative match. (AIDS/HIV, I&H, and PD)
   - TCM for CMI population under the Iowa Plan (managed care contract)
   - TCM as one of the services available under Iowa's "Habilitation services" (1915i State Plan)

3. Shifting to the requirements for TCM will take some time. Multiple changes will be required to implement the new regulations. These steps include:
   - State Plan Changes
   - HCBS Waiver Amendment
   - Rule Changes
   - DHS Manual Changes
   - Setting the unit price for each TCM provider
   - Provider and State system changes
   - Training of case managers on time keeping and documentation requirements
   - Educating Providers

The start date for the regulation is 3/3/08. We assume that a good faith effort to begin making the changes by 3/3/08 will satisfy the requirements of the regulation. Iowa has already started thinking and preparing for these changes.

4. Is it possible to get administrative match for activities included within the description of TCM activities where all TCM activities are not provided?

5. A Medicaid member must receive CM from a single case management provider agency and a single TCM. There will be more than one case manager involved during vacations, illness, and maternity leave. How does this meet the "single" case management requirement?

FREEDOM OF CHOICE of Providers and relating to services

6. There is a state law requiring accreditation by the DHS Division Mental Health /Disability Services of case management providers for the MR/DD/CMI, SED and Habilitation population.

   In order to be accredited a provider must be either a county, a subcontractor of the county or DHS. Medicaid recipients can only access accredited TCM's.

   Currently the Medicaid recipient can choose from any of the accredited Medicaid providers enrolled to provide Medicaid case management. The Case Management organization has many case managers and the Medicaid member has a choice within the organization. This provides choice for the Medicaid member. We are assuming that this is authorized under the freedom of choice regulation for the MR/DD/CMI population.

7. What does CMS use as the definition of MR, DD and CMI? Is mental retardation considered part of the DD population? Is SED considered CMI? Does an individual with a risk factor, which qualifies them for Habilitation, qualify them for CMI?

8. TCM services for children with CMI/SED are only available to children on the SED waiver and individuals on the MR/DD waivers must use State Plan TCM services. Individuals on the BI waiver or Habilitation must use State Plan TCM or HCBS case management as a service to receive BI waiver or Habilitation services. Is this still acceptable?

EIMBURSEMENT

9. Are we to assume that service coordination provided under administrative match is not required to follow these regulations and does not need to be reimbursed in 15-minute increments?

10. Can case management continue to be provided as an administrative match when it is necessary to implement the State Plan? (Related to Question 2)

11. Can case management continue to be provided as an administrative match for HCBS waivers? (Related to question 2)

12. In developing a unit price we assume that overhead costs, supervisor costs, staff travel, administration costs, equipment and supplies can be included in the calculation of the unit price.

13. Can the total number of minutes a case manager provides for a specific Medicaid member be added up at the end of the month and then divided into 15-minute units. This would decrease the amount paid significantly as only the exact time would be reimbursed instead on rounding for every contact.

14. Can there be a cost based rate with an annual cost settlement?

15. Can there be a monthly limit on amount, scope and duration? (i.e., $70.00 per month per legislation)

16. Iowa proposes to require case managers to use 15-minute unit record keeping starting 7/1/08. On 1/1/09 CM providers would turn in a 6-month cost report. 15 minute interim rates would be set for 1/1/09 forward. Final rates would be determined after the final cost report is approved. We assume this is an allowable way to transition to the 15-minute unit.

CARE PLAN

17. Is person centered planning a requirement? There are no specific requirements that state the process for this. If included, required or not, are States going to be matched to a standard?

18. Is there a minimum list that needs to be addressed in the comprehensive care plan in addition to medical social and educational?

19. Clarify the extent of "related documentation" (440.169d(1)ii) and "other sources" (440.169d(1)iii).

20. How extensive and what components are to be included in the "complete assessment" of the individual?

21. Clarify what has to be included in the case record? We assume it includes the assessment, history and the care plan along with what is listed in the regulation.

GATEKEEPER

22. The guidance states "A State also cannot condition receipt of case management services on the receipt of other services since this also serves as a restriction on the individuals' access to case management services."
    - If an individual is applying for Medicaid/HCBS and meets the target group population for TCM, can the assistance to apply for Medicaid be reimbursable as a stand-alone service? Can this be administrative match?

    - For individuals who are applying for TCM or HCBS services, can TCM provide assistance with the application/level of care determination and be reimbursed?

    - If the Medicaid member only wants TCM (State plan or waiver) to coordinate services outside of Medicaid funding (i.e. county), can this be reimbursed?

    - If a Medicaid member is receiving HCBS respite only and is required to receive case management, is case management allowed to be a billable service (only coordinating one service)?

    - If the Medicaid member is receiving HCBS and declines case management services, can the HCB services continue? Who is to assist in coordinating?

23. The State must have the final approval on HCBS care plans. The Medicaid member, case manager and interdisciplinary team identify the needs and services required. The Medicaid member and case manager develop a plan, which is now entered into ISIS and approved by the case manager. The interim regulation now states that the State must have final approval of the care plan. If the State sends out an NOD to the Medicaid Member confirming the approval of the care plan entered into ISIS, could this meet the "no gatekeeper except the state" requirement. (The NOD will target the appeal process)

INSTITUTIONAL TRANSITION

24. Transitional case management will only be allowed 60 days prior to leaving the institution. For States with Money Follows the Person demonstration grants, does this requirement apply? For Iowa, the target

population is individuals in ICF/MR who typically have no resources in the community or family. Case management was there to provide the connection that goes beyond the facility discharge planner. (Refer to MFP Case Study).

25. Self Direction Services

Self-Directed services, either state plan or HCBS waiver, typically has an Independent Support Broker (ISB) to assist with the self-directed budget. Along with this is usually a case manager who is assisting with traditional service or monitoring for health and safety. How does the TCM interim final rules relate to self-directed services and the role of the ISB?

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In the preamble to the proposed rule, CMS has explained that the administrative claiming and transportation reimbursement programs are susceptible to fraud and abuse. Those incidents should not lead to the elimination of a program beneficial to the health, welfare, and future value of our country's youth. Certainly, where problems exist, we should increase oversight and tighten up loopholes to discourage and prevent abuse.

The Commonwealth, its representatives, citizens, and children join in the hope that CMS will reconsider its pending actions, for the sake of the children we all serve.

Respectfully,

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Pennsylvania Comments on Targeted Case Management Regulations

Reference: File Code CMS-2237-IFC

Comments from the Pennsylvania Department of Public Welfare on the Interim Final Rule with Comment Period for the Medicaid Program: Optional State Plan Case Management Services.

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42 CFR Parts 431, 440, and 441

Introduction

In the "interim final rule" on Medicaid State Plan case management services, the Centers for Medicare and Medicaid Services (CMS) has issued regulations that will substantially alter the ways that states implement case management services for Medicaid recipients. While some of the regulations are issued in response to prior legislative actions, CMS goes far beyond the scope of the Deficit Reduction Act of 2005 to add additional requirements, such as requiring a single Medicaid case manager, limiting states' flexibility in the way that it pays for case management services, and reduced institutional transition time that will directly impact the ability of states to implement CMS initiatives, such as Money Follows the Person Demonstrations.

Pennsylvania recognizes that integrating the Medicaid case management system to support better coordination of services is a worthy and positive goal. Pennsylvania is actively engaged in integrating child serving systems so we recognize that if implemented carefully and with adequate planning, integration of services including case management services can improve program quality and benefit recipients. Unfortunately, these regulations do not achieve this goal and we believe they will hurt Medicaid recipients and the state's ability to provide home and community based services.

We strongly suggest that CMS delay the implementation of the case management regulations to allow Pennsylvania and other states to fully analyze the effect the regulations will have on the existing social service systems. Pennsylvania will require more time to effectively develop the necessary infrastructures that will be required to support the changes and ensure that Medicaid recipients are not adversely impacted in the process.

Provisions of the Interim Final Rule

Transition from institutions

The new case management regulations will undermine systems transformation that Pennsylvania is developing in partnership with CMS. Pennsylvania was awarded the Money Follows the Person (MFP) Rebalancing Demonstration by CMS and the Commonwealth is projecting to transition more than 2,600 people from institutions during this demonstration. In that Money Follows the Person is a CMS initiative, it is confusing that CMS would promulgate regulations that impede the ability of Pennsylvania and all other MFP Demonstration states to transition people from institutions. The regulations appear to completely undermine this opportunity.

The Money Follows the Person Rebalancing Demonstration specifically focuses on people who have been institutionalized for at least six months. The new transitioning period of "60 consecutive days," §440.169(c) is inadequate. This shortened transitioning time frame ignores the reality that people who live in institutions for six months or longer are generally more difficult to transition. These transitions take longer and are often more complex because the institutionalized person may have lost their home and their family support, thus it takes longer to make the accommodations for a successful transition. Moreover, these individuals may have complex physical and behavioral needs and may require additional time to transition back into the community. Currently the average transition period for long term nursing facility stays is over 90 days. The average transition period for people with mental retardation moving from state centers to community settings is 180 days.

In addition, Pennsylvania's Department of Public Welfare and Department of Aging have created a nursing home transition initiative that is central to rebalancing the long term living system. Developed and modified over years, nursing home transition is a collaborative initiative between the Departments and the Area Agencies on Aging and home and community based services providers. The initiative targets people recently admitted to nursing facilities. It offers them long term living counseling - information about services in the community - and helps the person and their family plan for a return to the community before they lose their homes and family support. It is a major effort that, since 2006, has resulted in over 2,500 people leaving nursing facilities and returning home.

People who participate in the nursing home transition initiative are generally in a nursing facility for less than six months. The CMS regulations only permit transition coordinators to be reimbursed for transition services for "the last 14 days before discharge," §440.169(c). Again, this limitation is inadequate for the purpose of transitioning. In addition, since this activity is conducted by the Area Agencies on Aging and other home and community based services providers as an administrative case management function, the Commonwealth must undertake extensive changes to the existing program which may further delay its progress in transitioning people from nursing facilities.

For people with mental health disabilities with inpatient hospital stays of less than 180 days, Pennsylvania will be required to reduce the time mental health case managers can be available to help with the transition process to 14 days. This will affect many individuals, who, due to the cyclical nature of mental illness, have repeated short inpatient stays.

The interim final regulations for case management appear to be oppositional to policy initiatives that have come directly from CMS. For years, CMS initiatives such as the New Freedom Initiatives and Real Choice grants have helped states develop infrastructures to support people with disabilities and seniors in their homes and communities instead of institutions. Truncating case management for transition from institutions will drastically hinder the very initiatives that CMS created.

Single Case Manager

In its interim final rule, CMS states that "case management services must be provided by a single Medicaid case management provider," §440.169(d). The single case manager must ensure coordinated access to necessary services across programs.

Pennsylvania has a rich and diverse social service system to ensure Medicaid recipients have access to services necessary for health and welfare. It is common for people who meet qualifications for needs across service systems to have separate case managers specific to each discipline, for example a case manager in the Mental Health service unit, and a case manager in the Mental Retardation service unit. These separate case managers are specialists in their fields and coordinate services when appropriate.

The Department believes it necessary to preserve some flexibility within the single Medicaid case manager requirement or quality of care will be jeopardized. Complex cases require special treatment. Program quality may suffer if a Medicaid recipient has to find all the requisite expertise in a single person. For example, a Medicaid recipient with a brain injury and substance use may be able to access all the necessary drug and alcohol use services, while the case manager may fail to recognize the additional services needed that are due to the brain injury, such as the recipient's physical health care access for a neuro-psychological evaluation and re-integration into the community with cognitive training. The case manager may not have the requisite specialized knowledge to assist this recipient.

Coordinated case management services can benefit Medicaid recipients, however, in order to integrate the service system to respond to the single Medicaid case management provider regulation we need additional time to make necessary infrastructure changes so that case management providers are ready to ensure access to services for the most difficult and complex recipient needs and flexibility to deal appropriately with complex or unusual cases.

Comprehensive Assessment

The interim final rule requires assessments that are "to be comprehensive in order to address all areas of need, the individual's strengths and preferences, and consider the individual's physical and social environments," §440.169(d)(1). The comprehensive assessment will inform the single case manager in order to facilitate coordination.

Each service system has developed its own assessment related to the recipients' needs for the services in the specific service system. Since this area has not previously been required, Pennsylvania needs adequate time to implement the regulation. The regulations create uncertainty about whether current assessment tools within Pennsylvania are sufficient to meet the regulation. Each system must review its

assessment and if necessary it must adapt its current assessment tool. This process cannot be done within the time frame of the regulations.

Limitations on Case Management Services

Provider Choice

CMS regulations require that "individuals must have the free choice of any qualified provider," §441.18 (a)(1). Pennsylvania's Area Agencies on Aging (AAA) are the sole provider of Medicaid case management for seniors. The regulations will have a substantial impact on the local infrastructure. It is impractical to expect such dramatic changes to an established social service network to adapt within the time frame directed in the regulations. This system change will require a well-defined, deliberate process that will necessitate the active involvement of the local community to ensure the changes will not disrupt the lives of seniors.

In addition, Pennsylvania's Office of Child Development and Early Learning is responsible for Pennsylvania's Infant, Toddler and Family Waiver. Families receive case management services through a designated local agency. The case managers are trained through Pennsylvania's statewide training system to assure quality and consistency. The case manager is the lynch pin of the Infant, Toddler and Family Waiver service system for children and their families. Choice of case management providers and the opportunity to opt out of receiving case management services significantly impact this system.

Case Management Services as an Option

Case management regulations state "a recipient cannot be compelled to receive case management services for which he or she might be eligible," §441.18(a)(2). If recipients refuse the case management service, CMS requires the key functions of case management to still be performed in order to ensure health and welfare and quality of care.

It is difficult to understand how the Commonwealth can ensure key functions of case management without actually providing case management, if the recipient refuses to have care coordinated on their behalf. Pennsylvania requests provisions to allow states to develop contingency plans and use federal funding to provide alternative case management in these situations. This provision will affect most Pennsylvania human service systems.

Rate Setting

The interim final rule requires "methods and procedures to assure that payments are consistent with efficiency, economy and quality of care." It expressly prohibits a bundled payment methodology and requires the "unit of service for case management service be 15 minutes or less," §441.18(a)(8)(vi).

To date CMS has approved a wide range of reimbursement methodologies for case management therefore each service system must review all existing methodologies, make proposals and implement new rates in order to adapt to the regulations. It will require Pennsylvania to amend every current case management and targeted case management section of the state plan, for both service and rate methods to ensure

descriptions conform to new regulations. These changes cannot be implemented in the time frame.

Pennsylvania's Area Agencies on Aging receive a monthly administrative rate that includes the provision of case management services. The changes in the regulation relating to the unbundling of services and the implementation of 15 minute intervals for billing purposes severely impacts the local administrative structure of these agencies, many of them county administered.

Pennsylvania has a county based human service system structure. These changes will involve multiple systems and require sensitivity to the local provider service system to ensure the community infrastructure does not erode. We must rely on these systems to adapt to changes that include not only fiscal but programmatic implications. Pennsylvania will be challenged to avoid loss to the human service system if counties must restructure as a result of the new regulations. This may result in a crisis that will ultimately affect people that rely on case management services. Again, Pennsylvania must have more time to implement the regulations to ensure a comprehensive and deliberate process across systems to bring them into compliance with new regulations.

Special Education

Case management regulations require "Medicaid case management services must remain apart from the administration of the IDEA programs. Medicaid may pay for those case management services where IDEA and Medicaid overlap, but not for administrative activities that are required by IDEA but not needed to assist individuals in gaining access to needed services," §441.18(c)(2).

Mental health case managers regularly attend IEP and IFSP meetings to assist in the development of children's plans to insure that behavioral health services needs are identified and addressed. It's not clear whether the interim final rule would eliminate this function and therefore interfere with important cross systems planning for children's services. Case managers are frequently present to share information concerning the outcomes of the IEP and IFSP meetings and discuss planning and coordination based on critical information shared within these forums with families requiring care coordination for their children.

Medicaid Agency Authority

The regulations state "providers of case management services cannot exercise the State Medicaid agency's authority to authorize or deny the provision of other services under the plan," §441.18(a)(6). Pennsylvania's Area Agencies on Aging (AAA) provide the level of care assessment function, case management and authorize services. If the AAA is no longer able to authorize services as the "gatekeeper" it may require additional complement of staff at the state level to handle these functions and a significant change to the infrastructure of the local agencies.

Also, within the Office of Developmental Programs the state by contract allows other entities to perform several administrative functions. This regulation has a potential for a dramatic effect on the mental retardation service system increasing the workload at the state level if those functions may no longer be performed by local administrative entities.

Administrative Case Management

CMS regulations state that "states may not claim, as administrative activities, the costs related to general public health initiatives, overhead costs, or operating costs of an agency whose purpose is other than the administration of the Medicaid program," §441.18(c)(5).

Mental health case managers are often a support to individuals in connecting with necessary service appointments. Case managers may assist consumers in accessing public transportation or may accompany a person to an appointment to serve as a liaison. These important functions would be eliminated by the interim final rule.

Pennsylvania agencies that claim case management as an administrative activity will be severely impacted by this change. It will take time for the Commonwealth to assess how to proceed and will require a state plan amendment to meet CMS requirements. We request swift approval of amendments in order to implement Money Follows the Person and other initiatives.

Conclusion

The interim final rule state plan case management regulations place an administrative burden on many Pennsylvania programs. Agencies will need to develop new procedures and protocols and provide training to allow for single case managers across multiple systems. In some cases it may mean redesigning the infrastructure of the way the agencies operate and could be a financial burden to the local entities. Pennsylvania must rely on the ability of the human services provider community to sustain the burden while the systems changes are coordinated. We estimate that the fiscal impact on our Behavioral Health programs alone would be nearly $20 million annually, but that is only part of the financial impact. The unknown total fiscal impact of these changes leaves the Commonwealth open to an infrastructure breakdown within the local communities that will affect Medicaid recipients.

Pennsylvania has a large stakeholder system of Medicaid recipients, families, advocates and human service provider agencies that will be touched in multiple ways by the implementation of the regulations. The Commonwealth greatly values stakeholder input and works hard to ensure a process where stakeholders can be consulted and share their views. We have benefited from these relationships and have years of satisfying history in working with our stakeholders to research, plan, develop and change policies and programs throughout the state. By promulgating interim final regulations, there will be no meaningful opportunity for stakeholder input. We believe that this truncated process will adversely affect program quality.

We believe that CMS has gone far beyond the intent of the Deficit Reduction Act and request that CMS reconsider the provisions, or engage in notice and comment rulemaking. These regulations will have profound implications for our human services system and stakeholder participation in the development of the infrastructure changes will be vital.